OSR 5-340# (4-14-97)
Stores: 26-8120.00

Do not use this form to file prescription drug claims. All prescription drug claims must be filed on a Drug Claim Form (OSR 5-341, Stores: 26-8122.00).

FOR OFFICE USE ONLY

MEDICAL BENEFITS CLAIM FORM

Plan Administrator:
WESTINGHOUSE SAVANNAH RIVER CO.

BlueCross BlueShield of South Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

Claims Processing Center
P.O. Box 100300
Columbia, SC 29202

1 **Insured's** Name _____

Social Security Number ___ ___ _____

2 **Patient's** Name _____
First Middle Initial Last

3 The **Patient** is: ☐ Female ☐ Male

And Is The:
☐ Insured ☐ Insured's Spouse ☐ Insured's Child

4 **Patient's** Date of Birth Month _____ Day _____ Year _____

5 Was any treatment required as a result of accidental injury? ☐ Yes ☐ No Date of accident _____

6 If an accident, was another person at fault? ☐ Yes ☐ No If yes, please explain.

_____

Was any injury or illness work related? ☐ Yes ☐ No

7 Is the patient covered by Medicare Health Insurance, Part A? ☐ Yes ☐ No

Or by Supplemental Medical Insurance, Part B? ☐ Yes ☐ No

If yes, please attach your "Explanation of Medicare Benefits." It is necessary to process your claim.

Complete the following Medicare Health Insurance Benefit Number # _____

Is the patient covered under any other health benefit plan? ☐ Yes ☐ No

If yes, please attach your "Explanation of Benefits" from the other Insurance Company and give the Policy Number

_____ . The following must be completed for processing of your claim.

8 A. Other Policyholder's Name _____

Relationship of other Policyholder to Patient _____

B. Name of other Policyholder's Employer _____

Address of other Policyholder's Employer _____
City State ZIP Code

C. Name of other Insurance Company _____

Address of other Insurance Company _____

CERTIFICATION OF MEMBER

9 I certify that the above information is correct and that the foregoing expenses were incurred for the above named patient. I request Comprehensive benefits for these expenses. I authorize any physician, nurse, hospital or other provider or supplier in possession of records or information concerning the patient to furnish such information to Blue Cross and Blue Shield of South Carolina upon request.

Date _____ **Insured's or Spouse's Signature** _____

(Be sure to complete items 1-9 on this form and attach itemized statements for all expenses. Absence of this information may cause your benefits to be delayed.)